Increase seniors' access to healthcare, enhance independent living, and reduce isolation primarily though transportation and visitation.

CLIENT APPLICATION

Date: _____/_____/_____

☐ Mr ☐ Mrs ☐ Ms ☐ Miss | Name: _____

Address: _____ Apt #: _____

Town: _____ Phone: _____

Detailed Directions: _____

_____

_____

E-Mail Address: _____ Are you a Veteran: ☐ No ☐ Yes

Church Affiliation: _____ Date of Birth: _____/_____/_____

How did you find out about Caleb Caregivers? _____

ASSISTANCE

Check off all that will assist you in remaining independent longer:

- ☐ Visiting
- ☐ Telephone Reassurance
- ☐ Yard Work (gardening, etc…)
- ☐ Transportation
- ☐ Light Housekeeping
- ☐ Light Home Chores/Repairs
- ☐ Food Box (CSFP) Delivery

Check off all of the following agencies/programs that are assisting you:

- ☐ Home Health
- ☐ Granite State Independent Living
- ☐ North Country Transportation
- ☐ DHHS (Dept. of Health and Human Services)
- ☐ Lifeline
- ☐ Other (please list): _____

_____

PLEASE COMPLETE BOTH SIDES OF THIS APPLICATION

EMERGENCY CONTACTS

Name: _____ Phone (H) ____/____/____ (W) ____/____/____

Address :_____Relationship: _____

E-Mail Address_____

Name: _____ Phone (H) ____/____/____ (W) ____/____/____

Address :_____Relationship: _____

E-Mail Address_____

Name: _____ Phone (H) ____/____/____ (W) ____/____/____

Address :_____Relationship: _____

E-Mail Address_____

MEDICAL HISTORY AND CURRENT CONDITION

Who is your primary physician? _____ Specialist? _____

Please give a brief medical history including surgeries, ongoing ailments, and risk factors:

_____

_____

Do you: ☐ Live alone ☐ Live with spouse/family ☐ Live with others

Are you: ☐ Able to get out independently ☐ Able to get out with assistance ☐ Homebound

Do you use: ☐ Cane ☐ Walker ☐ Oxygen ☐ Grab Bars ☐ Prosthesis ☐ Wheelchair

I hereby state that the information given by me, in this application, is true in all respects.

Signature:_____ Date:_____/_____/_____

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